BUILDING HEALTHY COMMUNITIES

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Healthy Communities: A Parable of Two Paths

In the early 1920's, the people of Prairie Center and Sunflower enjoyed a rich community life. There were strong ties among neighbors. People supported each other in many informal ways; through churches, in conversations at the local cafe, and on front porches. Adults cared for children not their own. When Billy or Maria did something wrong, their parents were sure to hear about it. People trusted others to look out for them.

Gradually life changed in each community. Growth from nearby urban areas added people with limited ties to the community. Local zoning laws—and regional planning—separated the places where people worked from those where they lived. Roads now cut through established neighborhoods, making it necessary to take the car to places people used to walk.

Individuals and families made new choices about how to use their time. Rather than visit neighbors, people stayed at home and watched television. Increasingly, both adults worked outside the home; often at several low-paying jobs to meet family needs. As a result, there were fewer adults to mind what kids were doing. All these individual choices and constraints added up: community folks had less contact with their neighbors, with their children, and with others' children.

In Prairie Center, things changed gradually, and so did the way local people addressed their problems. As drug use and violence increased in the 1980's and 1990's, the local media put the blame on youth and their parents. Following advice from outside experts, the county jail was expanded at considerable cost. This left less public money for education and health. Those who could afford it sent their children to private schools. Those who could went out of town for health care. Poor people suffered the most; sharp cuts in public assistance could not be made up by local churches and charities.

People still cared deeply about their OWN children and family members. But, the sense was that each person and family should take care of themselves. Many people were increasingly distrustful of THEM. "Them" was all those outside the family.

The people of Sunflower took a different approach. A tragedy in the late-1980's, deaths of two children in a drug-related incident, got people's attention. They began a process of community renewal. They started a dialogue about what really mattered to local people, and what values they shared. They identified a common purpose: creating a caring place for all our children.

The people of Sunflower began to work together in new ways. They formed action teams that cut across the usual boundaries; including both the powerful and those "labeled" people, such as youth and low-income families, who were seen by some as the problem. Now a diverse group of citizens, public officials, clergy, service providers, and business people joined hands.

They worked to transform schools, businesses, health and service organizations, the faith community, and other valued assets. They established benchmarks for success – all our kids succeeding in school, less drug and alcohol use, fewer teen pregnancies, fewer children living in poverty, and adults employed in decent jobs. They coordinated efforts in what they called the "Sunflower Partnership."

Gradually, people started to notice a difference with the unfolding of community changes, both large and small, in Sunflower. Several major businesses allowed flextime for their employees so they could help children. The school district expanded the hours of neighborhood schools, creating safe places for children after school. The faith community collected "pledges" to care for others. City government officials approved new guidelines for tax abatements that rewarded businesses for creating better paying jobs for the unemployed and working poor.

Taken together, these hundreds of changes improved community life. The differences could be seen: slowly, gradually. They also produced results: kids did better in school, fewer kids got in trouble, the neighborhoods were safer, and children and adults were more successful. There was more to be done, of course, but people saw signs of progress.

People from diverse backgrounds connected with each other in neighborhoods, workplaces, and around issues that mattered to them. They minded each other's children. They looked out for one other. They worked together in common purpose. In short, local people were more fully involved in the ongoing work of building a healthy community.

Building Healthy Communities: Some Orienting Ideas

Building healthy communities is the process of people working together to address health and development concerns that matter to them. As a process of community development[1], it is ongoing and gradual; not a one-time response to a political issue, such as crime, or an isolated campaign to address a crisis such as a drug-related tragedy. As a continuum of outcomes, it unfolds over time as incremental community (and systems) change, and related improvement in more distant indicators. Social ties and trust may contribute to, and result from, people working together in common purpose. Several orienting ideas help us understand this process of "building healthy communities."

Community refers to people who share a common place, experience, or interest. People may come together around issues that affect their place: the local block, neighborhood, city, town, or workplace. They may also connect because of shared experience due to race, ethnicity, disability, income, discrimination, or gender. Finally, people may find common purpose based on shared interest such as addressing child hunger, neighborhood safety, or drug use. In dialogue, we discover the commonality and diversity of experiences and interests that can unite people in place-based work.

Health (of individuals) can be defined as the state of complete physical, mental, and social well-being.[2] It refers to "a state of well-being and the capability to function in the face of challenging circumstances".[3] Health is not merely the absence of disease or infirmity.[4] Health is seen as a resource for everyday life, not the objective of living.[5]

Community health, also known as population health, refers to the state of collective well-being of people who share a common place or experience. What's the state of well-being for all of us who share this place? For our children and adolescents? For adults and older adults in our community? For the poor?

Community health and development issues that matter to local communities include those affecting: a) Physical well-being; for example, decent jobs, adequate housing, violence and public safety, child hunger and nutrition, teen pregnancy, heart disease, and injury; b) Mental well-being; for instance, substance abuse, academic failure, depression, and having meaningful work; and c) Social well-being; for example, caring relationships between children and adults, independent living of older adults, and support among family members, peers, and neighbors. Efforts to improve population health focus on changing the conditions in which health occurs.[6]

Determinants of health refer to conditions that affect health and well-being.[7] These include the: a) social environment and prosperity (e.g., family structure; educational system; health services; social networks; social class; household income; disparity of income); b) physical environment (e.g., barriers in the physical design of the environment; exposure to hazards and toxic substances; poor housing conditions and overcrowding); and c) genetic endowment (i.e., hereditary factors that increase or decrease risk for health outcomes; e.g., the biological basis for alcoholism, mental disorders, and heart disease).[8] Social determinants refer to those environmental features, such as trust and social ties, that affect health and well-being through relationships and exchanges among people.

Social Determinants, Social Capital, and Community Capacity

Population-level research—with whole communities, states, and nations—suggests the strong effects of economic circumstances and social features on a community's health status. For example, Wilkinson's[9] cross-national, comparative research showed a strong correlation between income inequality, the gap between those with most and least income, and death from a variety of causes. Kaplan and colleagues[10], using data from all 50 states of the United States, demonstrated a similar relationship between income distribution and mortality. Also, research with British civil servants by Marmot and colleagues[11] suggests a strong inverse relationship between social class (i.e., job classification) and mortality. In a rare experimental study, a marked increase in income (due to a negative income tax) resulted in improved health outcomes (i.e., significantly heavier babies at birth).[12] In a comprehensive review of the literature on social determinants of health, Feinstein[13] concluded that there is a strong and consistent link between wealth, education, and health outcomes. Yet, income disparity has grown in the United States since 1973; with the rich getting richer and the poor getting poorer.[14,15]

The idea of social capital—civic engagement and trusting relationships among people—is thought to help explain how income is associated with outcomes in health and development.[16,17] Kawachi et al.[18] examined the relationships among income inequality, social capital (civic engagement and level of trusting relationships) and health outcome (all cause mortality) at the state level. Their research suggests that the more social capital (civic engagement and trust) the better the health outcome. Further, researchers speculate that a decline in social capital—people watching more television, and accordingly, less engaged with their neighbors—may help explain a rise in a variety of adverse societal outcomes.[19,20]

Less clear are the mechanisms by which social determinants (including poverty and social capital) might influence health outcomes. For example, does social capital increase the likelihood that people will be able to transform the environment in ways that improve health? Perhaps when people trust each other, they are more likely to be engaged in community building efforts. Or, is social capital a bi-product of successful efforts to transform communities, and related health improvement? Perhaps as communities improve, more people get involved and trusting relationships are developed. Or, does increased social capital affect health directly; for instance, a sense of belonging may reduce stress and improve physical and mental health. Do other factors—perhaps poverty and income disparity, and related stressors and barriers—affect the conditions under which both health and social ties occur? Perhaps the stressors of trying to meet basic needs in the face of poverty reduce access to health resources and the basic conditions that affect health. Also, social comparisons that focus on disparities in wealth between community members may limit their willingness to connect with others, or to get involved on their behalf. Further research may help clarify how income inequality and social capital—and related variables—interact to affect community health.

Although social scientists[21,22] have asserted the importance of social capital and cited possible reasons for its apparent decline, few have brought forth tangible ways of how communities can propagate it.[23,24] One promising strategy for enhancing social capital—and less directly, income inequality, and community health—is to support collaborative partnerships. Collaborative partnerships are ecological systems[25] that encourage community engagement around local concerns.[26] They create niches of opportunity for, and reduce barriers to, successful community engagement; and, thereby, may increase trust. They can encourage community engagement that transforms the local environment, and the broader policy changes that produce a more equitable distribution of resources.[27] By increasing civic engagement and equality of opportunity and result, collaborative partnerships focus on two variables associated with health and development outcomes: social capital and income inequality.

Finally, success in addressing the determinants of health may be related to community capacity. Community capacity refers to the ability of local people to work together to affect conditions and outcomes that matter to them; and to do so over time, and across concerns.[28,29] Markers of community capacity include community action and resulting change in conditions and outcomes (e.g., community and systems change; improvement in community-level indicators). To reflect capacity, community (systems) changes should occur over time (i.e., be sustained) and occur across concerns (i.e., when a new issue or goal is identified, changes are brought about related to these new goal areas).

Understanding the Context of Public Problem Solving

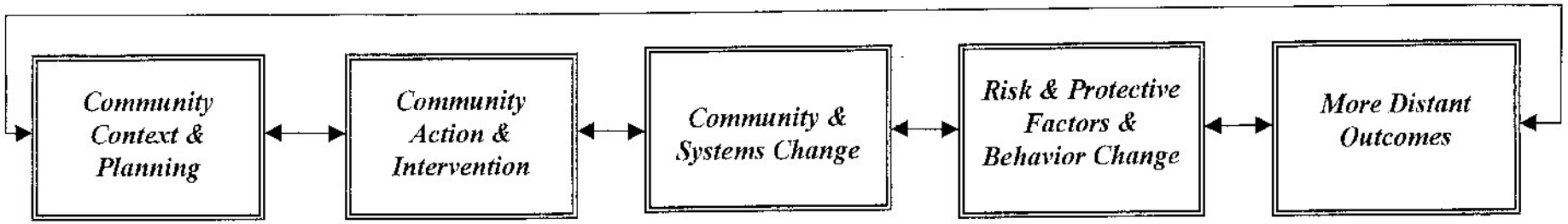
Building healthy communities requires public problem solving: people engaged in addressing issues of health and development that matter to them. Community-wide engagement in public problem solving is affected by our assumptions about the nature of public life,

problems, and solutions.[30] Some assumptions, such as that solving problems together builds trust, may advance common work; others, such as "nothing works," may impede it.

First, assumptions about the nature of public life—and who is responsible for public problems—can enhance or impede the work.[31] Two myths may be central to disengagement of citizens from public life: first, the notion that public life is a battleground for selfish interests; and second, that public life is only for experts, officials, and celebrities.[32] Business and special interests do have disproportionate influence; and public life does bring together people with different values, and disagreement, even conflict, may result. But self-interest and conflict are not the core of public life. Indeed, public life is also a vehicle for individual and community growth. We all have a public life. Through ties in our family and workplace, and with friends and neighbors, we help each other deal with what matters; serving and being served, protecting and being protected.

Second, beliefs about the nature of public problems—for example, whether problems originate in people[33] or in their environments[34]—may limit or advance community engagement in problem solving. Too often, we frame public problems as being in *those* people abusing substances or in *that* group with the high crime rate.[35] This prevents others from seeing how the problem affects their lives, and from participating in the solution. More truthfully, public problems are shared by all of us. For example, the health and development outcomes for a child born addicted to drugs are not only related to conditions in the past and current environment; they are also tied to future economic security and well-being for that child, his or her family, and the community. Crime and violence associated with poverty not only affect the businesses, playgrounds, and streets of low-income neighborhoods; they extend into, and originate from, the surrounding community.

Building Healthy Communities: A Community Development Model*



Community organization among people who share a common:

- Place
- Work situation
- Experience or concern

Context of the work:

- Hopes and expectations
- Deprivation
- Histories of cooperation and conflict
- Consensus on goals and means
- Strength and depth of leadership
- Financial resources
- Sanction (or resistance)
- Broader political and social context

Planning products:

- Vision
- Mission
- Objectives
- Strategies
- Action plan

Strategies for action (and contexts):

- Social planning (consensus or conflict)
- Social action (conflict)
- Locality development (consensus)
- Collaborative partnership (consensus)

Opposition (and resistance):

- Deflect attention
- Delay response
- Deny problem or request
- Discount problem or group
- Deceive the public
- Divide and conquer
- Appease with short term gains
- Discredit group members
- Destroy the group

Intervention components:

- Targeted mission
- Action planning
- Leadership
- Hiring community mobilizers
- Technical assistance
- Documentation & feedback
- Making outcome matter

Community changes (i.e., new or modified programs, policies and practices) relevant to community concerns

Systems changes (i.e., new or modified programs, policies, and practices) in the broader environment

Resources generated (i.e., direct grants; grants brokered; in-kind contributions)

Personal/Group factors:

- Knowledge and skills
- Values and beliefs
- Degree of health or impairment

Environmental factors:

- Family and peer support
- Models and mentors
- Resources and opportunities
- Density of positive reinforcement
- Environmental barriers and hazards
- Poverty and deprivation
- Policies, laws, and culture

Behavior changes: (e.g., Abuse of substances, unsafe sexual activity, school performance)

Illustrative outcomes that matter to local communities:

- Health (e.g., adolescent pregnancy; HIV/AIDS; deaths due to substance abuse; deaths due to violence; injury)
- Well-being of children, youth and families (e.g., child abuse and neglect; caring adults)
- Education (e.g., school readiness; academic achievement)
- Economic well-being (e.g., employment; household income)

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